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MY
SUMMER TRAINING
REPORT
PRESENTATION

Summer Training Report
By
Dr. Savan Vekariya
(0989)

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UNDER THE GUIDANCE OF,
DR. ARINDAM DAS
ASSOCIATE PROFESSOR, CHAIRPERSON (Ph.D PROGRAM)
IIHMR UNIVERSITY JAIPUR



PART 1

A COMPARATIVE STUDY ON THE ASSESSMENT OF ROUTINE IMMUNIZATION IN RURAL AND URBAN AREAS OF GUJARAT

INTRODUCTION

- ❖ Immunization is the process whereby a person is made immune or resistant to an infectious disease, typically by the administration of a vaccine. Vaccines stimulate the body's own immune system to protect the person against subsequent infection or disease.
- ❖ Immunization is a proven method to monitor and eradicate life-threatening infectious diseases and is expected to prevent 2 to 3 million deaths a year.
- ❖ This is one of the most cost-effective health initiatives, with validated approaches making it available to even the most disadvantaged and hard-to-reach communities.
- ❖ It has specifically identified target groups; it can be easily implemented by outreach activities; and vaccination involves no significant changes in lifestyle.

Types of Immunization:

Active Immunization

Passive Immunization

BACKGROUND

- ❖ In recent years India has made great strides in increasing the coverage of immunization.
- ❖ Estimated coverage for diphtheria, tetanus, pertussis dose 3 (DTP-3) ranged from 59% to 65% between 2000 and 2007, which is widely used as a proxy for general immunization coverage.
- ❖ Since then, coverage of DTP-3 has gradually improved in India.
- ❖ In 2016, DTP-3 coverage was reported at 88% by the WHO.
- ❖ Although this is a major change, the Indian population still has pockets of considerably lower coverage of the immunization

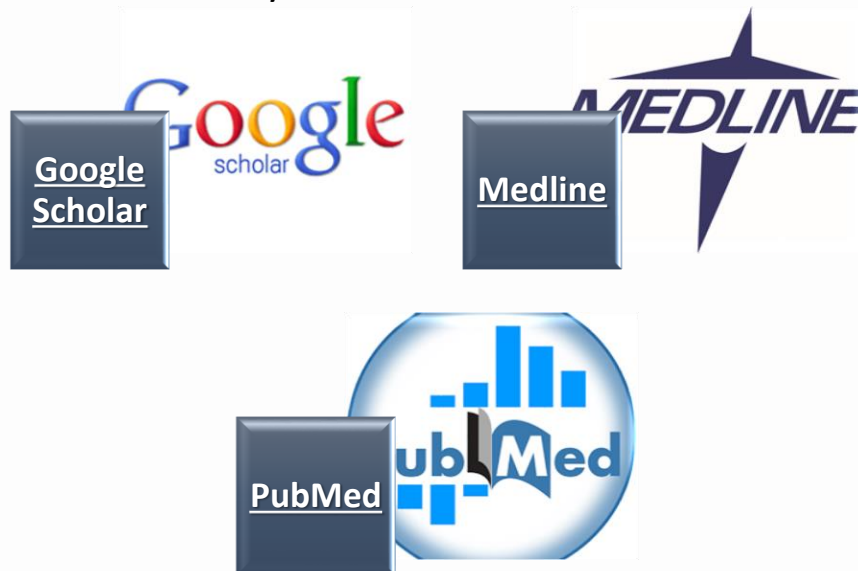
- ❖ Gujarat, a state in western India, has a population of over 60 million people and is considered to be a medium-performing immunization coverage area.
- ❖ According to either vaccination card or mother's study in 2009, Gujarat reported immunization coverage
 - ✓ One dose of Bacillus Calmette – Guérin(BCG) vaccine,
 - ✓ Three doses of diphtheria, pertussis and tetanus(DPT) vaccine,
 - ✓ Three doses of oral polio vaccine(OPV),
 - ✓ one dose of vaccine-containing measlesof 56.6% for children aged 12–23 months.

OBJECTIVE

- ❖ The aim of the study is to compare the vaccination coverage in the rural and urban areas of Gujarat.

METHODOLOGY

- ❖ Secondary data was collected from:



- ❖ A variety of data sources, including data collected from various governmental agencies that captured the coverage of immunization information.
- ❖ Some of the major sources that have been used include the,

Census India 2011

National Family Health Survey (NFHS) 2015-16

WHO/UNICEF joint report on immunization 2017

National Health Mission (NHM) Immunization Coverage

SUMMARY OF REVIEWED LITERATURE

YEAR PUBLISHED	PLACE	OBJECTIVE	SAMPLE SIZE/ SOURCE OF DATA	KEY FINDINGS
2011	Anand District, Gujarat.	Assessment of regular process components of immunisation	44 PHC, 88 immunization sessions evaluated	There is a short supply of vaccines with the concern for wastage, which needs to be avoided. Short staffed healthcare facilities

YEAR PUBLISHED	PLACE	OBJECTIVE	SAMPLE SIZE/ SOURCE OF DATA	KEY FINDINGS
2017	Jamnagar District, Gujarat.	To assess the cold chain maintenance of immunization	20 PHCs, 10 CHCs	5 PHCs and 1 CHC had unqualified personnel in-charge for the maintenance of cold storage. - Internal storage required better management even though most fit for daily immunization in the district

YEAR PUBLISHED	PLACE	OBJECTIVE	SAMPLE SIZE/ SOURCE OF DATA	KEY FINDINGS
2015	Ahmedabad District, Gujarat.	To find fully/partially and non immunized children in the rural and urban areas along with the reasons and measures	2851 Children	Coverage seen in the study was better than that shown in National surveys, yet issues such as partial and no coverage need to be assessed and steps taken accordingly

YEAR PUBLISHED	PLACE	OBJECTIVE	SAMPLE SIZE/ SOURCE OF DATA	KEY FINDINGS
2015	Kheda District, Gujarat	To find the immunization coverage of the region and the reasons associated with lack there of.	462 women with children aged between 12 and 23 years	28% of the children were either partially or not immunized due to 3 main reasons given by mothers, which are- Lack of awareness about immunization, or the second and third booster dosage.

YEAR PUBLISHED	PLACE	OBJECTIVE	SAMPLE SIZE/ SOURCE OF DATA	KEY FINDINGS
2018	Gujarat	To assess clinical level immunization provision in the 2 districts of Gujarat	10 PHCs	Obstacles in immunization included; • Vaccine storage facilities, • Reach to communities, • Poor internet access • Cold chain equipment malfunction

YEAR PUBLISHED	PLACE	OBJECTIVE	SAMPLE SIZE/ SOURCE OF DATA	KEY FINDINGS
2016	Ahmedabad District, Gujarat	To evaluate immunization coverage in Urban slums.	214 children between 24 and 35 month age group	Vaccination coverage higher for 1st dose of BCG and OPV, while dropout rate was higher for the 3rd dose. Overall, 75.7% of Children between the said age group were fully immunized

YEAR PUBLISHED	PLACE	OBJECTIVE	SAMPLE SIZE/ SOURCE OF DATA	KEY FINDINGS
2019	Jamnagar District, Gujarat	1) To evaluate vaccination coverage in the urban slums 2) Ascertain causes of partial and non immunization	Two stage sampling. First stage- 30 Anganwadi Second stage- & children (12-23 months)	Maternal education, socio-economic factors influenced immunization rate. Partial and non immunization was reasoned with lack of awareness by the mothers.

YEAR PUBLISHED	PLACE	OBJECTIVE	SAMPLE SIZE/ SOURCE OF DATA	KEY FINDINGS
2010	Ahmedabad District, Gujarat.	To determine immunization tolerance and knowledge of mothers.	100 mothers with children < 5 years of age	Low literacy among mothers was a concern causing poor immunization coverage which could be remedied with the help of Anganwadi staff and television

RESEARCH FINDINGS

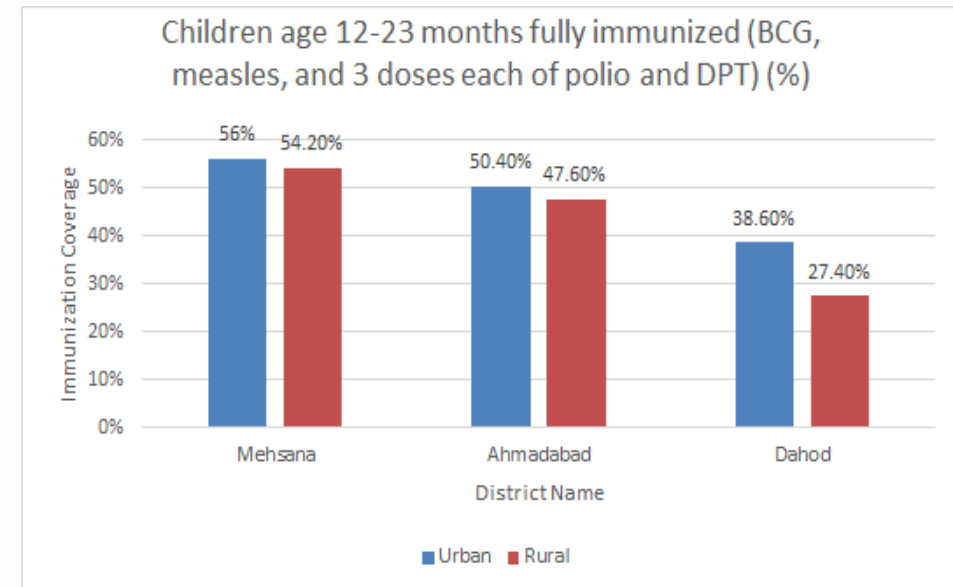
The various indicators used for the purpose of this study is as follow:

Children age 12-23 months fully immunized (BCG, measles, and 3 doses each of polio and DPT) (%)

Children age 12-23 months who received most of the vaccinations in public health facility (%)

Children age 12-23 months who received most of the vaccinations in private health facility (%)

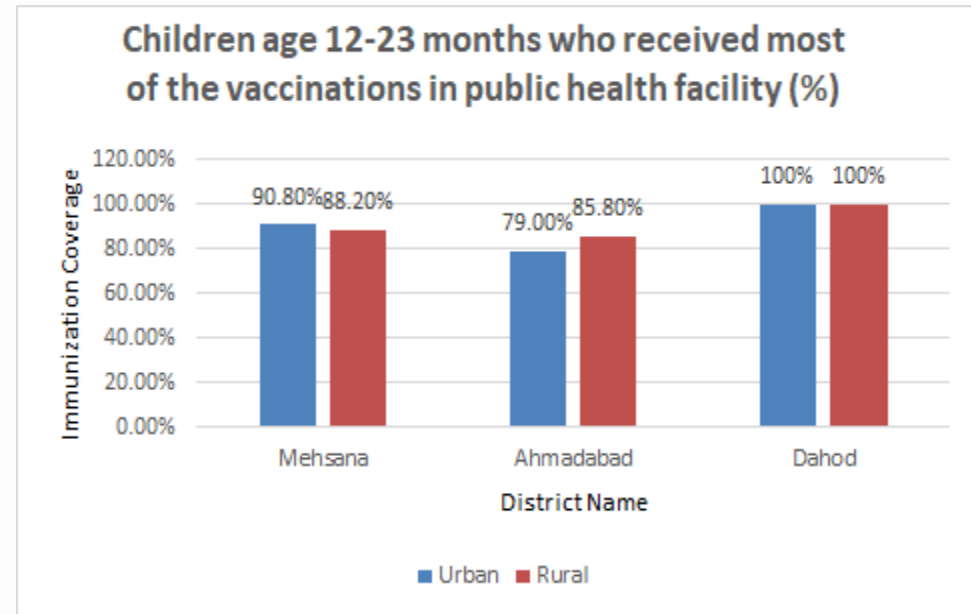
Children age 12-23 months fully immunized (BCG, measles, and 3 doses each of polio and DPT) (%)



- ❖ In Mehsana district of Gujarat there were children aged 12to23 months fully immunized including BCG, measles and three doses each of polio and DPT was 56% in urban areas and 54.20% in rural areas.

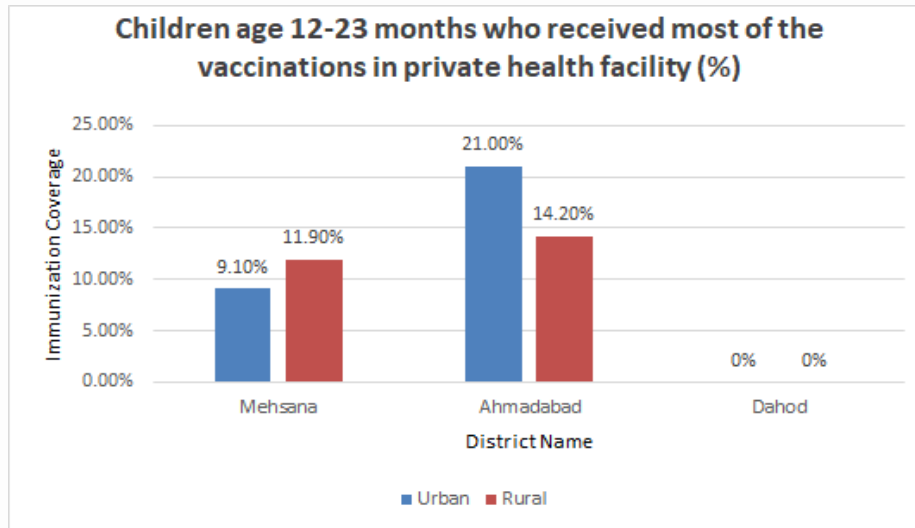
- ❖ In Ahmedabad district there were 50.40% in urban area and 47.60% in rural area.
- ❖ In Dahod district there were 38.60% in urban area and 27.40% in rural area.
- ❖ Lack of awareness about immunisation is considered to be one of the contributing factors to low immunisation rates.
- ❖ Literacy rates in Mehsana, Ahmadabad and Dahod is 83.61%, 85.31% and 58.82% respectively.
- ❖ This could be the reason why Dahod has a lower IR as well as, that seen in rural when compared to Urban.
- ❖ Lack of awareness also leads to partial immunisation, because more often than not parents are not aware of the next schedule.
- ❖ Single one day immunisation camps do help in providing the first shot of vaccination but fail to sustain it in the long run.

Children age 12-23 months who received most of the vaccinations in public health facility (%)



- ❖ The lesser developed city of Dahod depends on public healthcare facilities for the purpose of vaccination.
- ❖ While cities like Mehsana and Ahmadabad to a small extent get vaccination from private hospitals and healthcare facilities as well.

Children age 12-23 months who received most of the vaccinations in private health facility (%)



- ❖ Much of Gujarat is dependant on its public healthcare facilities.
- ❖ Due to private healthcare facilities being expensive for most middle-class population of Gujarat, public facilities are used more often by those who do get vaccination done.
- ❖ Reluctance to use public facilities and inability to afford private, could be a one of the contributing factors to low immunization rate.

CONCLUSION

- ❖ While the difference in immunisation rates between urban and rural areas of the 3 districts of Gujarat is not staggering, and almost comparable, there is still a difference seen between the districts which could be due to various factors such as human development, literacy rates.
- ❖ Despite being the 3rd richest state in India, The immunisation rate of Gujarat is in the bottom five being better than only Nagaland, Arunachal, D&N Haveli and Assam.
- ❖ The reason for this could be poor management of public health facilities, unavailability of doctors, disparity between vaccination reaching the public.

PART 2

E-health: More than just an electronic record

By:



Course Description

- ❖ This massive open online course "E-Health: More than just an online record!" is multidisciplinary in nature, seeks to empower the global public of health practitioners, teachers, executives, administrators and researchers to focus on the potential effect of eHealth on the transformation of treatment.
- ❖ It discusses the scope of technology use, current and emerging developments, and highlights eHealth practice and research both at the local and international levels.

- ❖ The whole E-Health Course consists of 5 modules and is completed for around 5 weeks.
- ❖ Certificates of completion are given after participation of all 5 modules.
- ❖ Completing the health practice assignment in Module 5 entitles you to advanced standing in some of the E-Health courses run by the University of Sydney's Faculty of Health Sciences.

Objectives of the Course

- ❖ The fundamentals of E-Health.
- ❖ What Kind of Health data we are currently collecting & how it will transform healthcare in future?
- ❖ How new technologies are helping health consumers participate in their own healthcare.
- ❖ How E-Health can improve the coordination and efficiency of healthcare.

Course Contents

☐ Week 1 - What is E-Health?

- In this Module 1, Key question: "What are the E-Health fundamentals, and where are they heading?"
- You will need to view the video lectures for each lesson to complete this introductory module and complete the four listed ungraded learning activities.
- It's also suggested that you review the reference module and additional tool list to refine your learning.

☐ Week 2 - Health in our Hands

- In This Module 2, Key question: "How are emerging innovations helping customers 'participate' in healthcare?"
- You will need to watch the video lectures for each lesson and complete the two mentioned ungraded learning activities to complete this module.
- As per the assignment instructions, you are also expected to complete the graded Peer Review Assignment 1 (40%) for submission.

☐ Week 3 - Data and the "Quantified Self"

- In This Module 3, Key question: "What kind of health data are we gathering now and how is it going to transform health care in the future?"

☐ Week 4 - Interacting with Health Professionals using New Technologies

- In this Module 4, Key question is "How can E-Health enhance healthcare communication and efficacy, and what are the barriers?"

☐ Week 5 - E-Health in Professional Practice

- In the Module 5, key question: "How can the principles and techniques of E-Health be implemented in my own job practice?"

Learning Methodology used in the course

- ❖ In this course, online learning provided by following:



Lecture Videos



Reading
Materials



Quizzes



Assignments

Key Learnings from the Course

❑ Week 1 - What is E-Health?

- E-Health is the cost-effective and secure use of ICTs in support of health & health-related fields.
- According to me, E-health is the use of internet & other healthcare technologies to increase access, effectiveness, efficiency & quality of service used by healthcare agencies, patients, healthcare practitioners & customers use HIT to enhance patient health status.
- E-Health is essentially the use of technology in medicine and engineering, and any area related to helping people with their wellbeing.

❑ Week 2 - Health in our Hands

- Wearables collecting your own data-Now-a-day people use their phones to click blood pressure stats, pulse, weight, BMI connecting via Wi-Fi gets BP results that motivates them to look after their health. Wearable devices which communicate with apps are one of the bigger trends.
- Using apps, mobile devices, sensors, etc. is commonly referred to as mHealth or Mobile Health and some examples of mHealth in education and awareness using it as a help line for providing evaluation, and remote monitoring and data collection support for treatment. These can also be used for monitoring disease and infection outbreaks.
- Governments use the social media to encourage health awareness and to collect data.

❑ Week 3 - Data and the "Quantified Self"

- Digitizing paper records is clearly beneficial. It enables a patient's medical history to be tracked over time. To alert patients for routine or follow up consultations, to monitor patients' vital signs. And overall, to improve the quality of care.
- Predictive Medicine and Precision
- Use E-Health can ensure we can obtain the recorded patient results from patients effectively. We should evaluate and test certain steps in order to achieve a result that is useful to physicians.
- Privacy & Security of patient's recorded data with encryption.

❑ Week 4 - Interacting with Health Professionals using New Technologies

- Improving health-care coverage.
- Support of health care Professionals by bringing the health communities together.

❑ Week 5 - E-Health in Professional Practice

- There are lot of E-health examples in professional practices:



Medlife



My Physio App



My Home
Dialysis



Aarogya Setu
App

THANK YOU